# 1991

# GUIDE

# To Health Insurance for People with Medicare

★ **SOME BASIC THINGS YOU SHOULD KNOW**

★ **TYPES OF PRIVATE HEALTH INSURANCE**

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★ **WHAT MEDICARE PAYS AND DOESN'T PAY**



**Developed jointly by the National Association of Insurance Commissioners and the Health Care Financing Administration of the U.S. Department of Health and Human Services.**

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# NOTICE

LISTED IN THE BACK OF THIS BOOKLET ARE THE ADDRESSES AND TELEPHONE NUMBERS OF EACH OF THE STATE AGENCIES ON AGING AND THE STATE INSURANCE DEPARTMENTS. THEY ARE AVAILABLE TO ASSIST YOU WITH ANY QUESTIONS YOU MAY HAVE ABOUT PRIVATE INSURANCE TO SUPPLEMENT MEDICARE, OR SO-CALLED "MEDIGAP" POLICIES. SUSPECTED VIOLATIONS OF THE LAWS GOVERNING THE MARKETING OF THESE POLICIES SHOULD GENERALLY BE REPORTED TO YOUR STATE INSURANCE DEPARTMENT SINCE STATES ARE RESPONSIBLE FOR THE REGULATION OF INSURANCE WITHIN THEIR BOUNDARIES. THERE ARE ALSO FEDERAL PENALTIES FOR CERTAIN VIOLATIONS CONCERNING MEDIGAP POLICIES. IT IS, FOR EXAMPLE, A FEDERAL OFFENSE FOR AN INSURANCE AGENT TO INDICATE THAT HE OR SHE REPRESENTS THE MEDICARE PROGRAM OR ANY OTHER FEDERAL AGENCY IN ORDER TO SELL A POLICY. THE FEDERAL TOLL-FREE TELEPHONE NUMBER FOR REGISTERING SUCH COMPLAINTS IS:

**1-800-638-6833.**

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## SOME BASIC THINGS YOU SHOULD KNOW

If you are like most older Americans covered by Medicare, there are many things about the federal health insurance program that you do not understand. You probably are uncertain about what Medicare covers and doesn't cover, and how much it pays toward your medical expenses. And, like most other beneficiaries, you want to know what, if any, additional health insurance you should buy.

This booklet will help you clear up those uncertainties. It will give you a better understanding of both your Medicare benefits and the types of private health insurance available to supplement Medicare. With this new knowledge, you will be better prepared to decide whether you need additional insurance to fill the gaps in Medicare and, if so, what type would best meet your needs.

### What is Medicare?

Medicare is a federal health insurance program for people 65 or older, people of any age with permanent kidney failure, and certain disabled people under 65. It is administered by the Health Care Financing Administration (HCFA) of the U.S. Department of Health and Human Services. The Social Security Administration provides information about the program.

Medicare has two parts—hospital insurance (Part A) and medical insurance (Part B). Hospital insurance helps pay for medically necessary services furnished by Medicare-certified hospitals, skilled nursing facilities, home health agencies, and hospices. Medicare medical insurance helps pay for physician services and many other medical services and supplies that are not covered by Part A. (The Medicare benefits are explained in more detail on pages 10 through 15.)

While Medicare pays a large part of your health care expenses, it does not pay them all. You or your insurance company must pay certain amounts called deductibles and coinsurance. And because there are limits on how much Medicare will pay for some covered medical services, supplies and equipment, you or your insurance company are responsible for paying all charges in excess of Medicare's limits. There also are various medical services and supplies Medicare does not cover.

### Definitions of Medicare Terms

Before describing the different types of private insurance available, it will be helpful to define some of the terms used by Medicare such as:

* **approved amount,**
* **coinsurance,**
* **excess charge,**
* **deductible,**
* **assignment,**
* **participating physician and supplier, and**
* **benefit period.**

Medicare's approved amount, which is also referred to as the **reasonable** or **allowable** charge, is the heart of its Part B payment system. Here's how Medicare determines the approved amount for most Part B claims:

When a doctor submits a claim, the private insurance companies that process the claims for Medicare (they are called Medicare carriers) compare the bill submitted with the doctor's customary charge and with the prevailing charge in the community for the particular service. The lowest of the three becomes the "**approved amount.**"

Medicare generally pays 80 percent of the approved amount; you pay the remaining 20 percent. The portion of the approved amount you pay is called **coinsurance**. If the physician's fee is higher than the Medicare approved amount, you or your insurance company must pay the difference. That is called the **excess charge.**

You or your insurance company also must pay Medicare's deductibles. A **deductible** is an amount you or your insurance company must pay before Medicare starts paying. The Part A deductible in 1991 is $628 per benefit period. The Part B deductible for 1991 is $100 per calendar year. This means that if you are admitted to the hospital, you must pay the first $628 for Medicare-covered services. If you go to the doctor, you must pay the first $100. While you pay only one Part B deductible a year, no matter how many times you visit a physician, you may end up paying more than one hospital deductible annually if you are hospitalized more than once.

Because you cannot tell in advance whether the approved amount and the actual charge for covered services and supplies will be the same, always ask your physicians or medical suppliers whether they **participate** in Medicare or **accept assignment** of Medicare claims.

Those who take **assignment** on a Medicare claim agree to accept the Medicare-approved charge as payment in full. They are paid directly by the Medicare carrier, except for the deductible and coinsurance amount that you must pay. For example, if you go to a participating physician and the Medicare approved amount for the service you receive is $300, you would be billed by the physician for 20 percent of the amount, or $60, assuming you had already met the $100 Part B deductible for the year. The other $240 would be paid by Medicare.

### Participating Physicians

Physicians and suppliers who sign Medicare participation agreements accept assignment on all Medicare claims. Their names and addresses are listed in *The Medicare Participating Physician/ Supplier Directory*. The directory is distributed to senior citizen organizations, all Social Security Administration and Railroad Retirement Board offices, all hospitals, and all State and area offices of The Administration on Aging. The directory may also be obtained free of charge from the insurance carrier that processes Medicare Part B claims in your area (see the back of *The Medicare Handbook* for the list of carrier addresses), or you can call the carrier to find out which doctors and suppliers are Medicare participants.

### Non-Participating Physicians

Even if your physician or supplier does not participate in Medicare, ask before you receive any services whether he or she will accept assignment of your Medicare claim. Many physicians and suppliers accept assignment on a case-by-case basis. If your physician or supplier does not accept assignment, you or your insurance company must pay the bill. Medicare will then reimburse you its share of the approved amount after the physician or supplier files your claim, as required by law. All physicians and qualified laboratories must accept assignment for Medicare-covered clinical diagnostic laboratory tests. Physicians also must accept assignment for covered services provided to beneficiaries with incomes low enough to qualify for Medicaid payment of their Medicare cost-sharing requirements (see page 7).

While private insurance is available to cover most or all of the gaps in Medicare, there are situations in which all of your medical costs might not be covered even if you have private supplemental insurance. For example, suppose your Medigap policy did not cover charges in excess of Medicare's approved amounts and your physician charged $375 for a service for which the Medicare approved amount was $300.[1] You would have to pay the $75 excess charge plus the $100 Part B deductible, unless your insur-

[1]As of January 1, 1991, physicians who do not accept assignment of Medicare claims were limited as to the amount they can charge a Medicare beneficiary for covered services. In 1991, charges for medical evaluation and management services cannot exceed the Medicare approved amounts by more than 40 percent. Charges for other covered medical services cannot be more than 25 percent higher than the Medicare approved amounts.

ance covered the deductible or you had already paid it for the year. Medicare would pay 80 percent of the balance and your insurance would cover the other 20 percent.

Medicare uses a different system to pay hospitals than it uses to pay physicians. If you are hospitalized, Medicare will pay for all covered services during the first 60 days of a benefit period except for the deductible. If your stay is longer than 60 days, you must pay coinsurance for each additional day of covered care, up to a maximum of 150 days per benefit period (see page 12.)

A **benefit period** is a way of measuring your use of services under Part A. Benefit periods, which apply to hospital and skilled nursing facility care, begin the day you are hospitalized and end after you have been out of a hospital or skilled nursing facility for 60 days in a row. A benefit period also ends if you remain in a skilled nursing facility but do not receive any skilled care for 60 days in a row.

### Gaps in Medicare Coverage

What are the gaps in Medicare coverage? In general, they are the:

* **deductibles,**
* **coinsurance amounts,**
* **charges in excess of Medicare's approved amounts, and**
* **various medical services and supplies that Medicare does not pay for.**

While Medicare helps pay a large portion of your health care costs, there are many things Medicare does not cover. Among the things Medicare cannot pay for are: custodial care, such as help with bathing, eating, and taking medicine; eyeglasses, hearing aids, and examinations to prescribe or fit them; a phone, TV, or radio in your hospital room; most outpatient prescription drugs and patent medicines; private room; routine dental care; routine physical checkups; and medical care received outside the United States, except for certain limited situations in Canada and Mexico.

## TYPES OF PRIVATE HEALTH INSURANCE

A variety of private insurance policies are available to help pay for medical expenses, services and supplies that Medicare either does not cover or does not pay in full. The basic types of policies include Medicare supplement, or "Medigap" insurance, hospital indemnity insurance, nursing home or long-term care insurance, specified disease insurance, and coordinated care plans (these include health maintenance organizations [HMOs] and competitive medical plans [CMPs]).

### Medigap

Medigap insurance is private health insurance designed specifically to supplement Medicare's benefits by filling in some of the gaps in Medicare coverage. Most States have adopted the federal standards for such policies. The standards include minimum benefit requirements. Insurers may add other benefits to the basic policy. Medigap policies generally pay some or all of Medicare's deductibles and coinsurance amounts. Some policies may also pay for limited health services not covered by Medicare. Because insurers have some flexibility in deciding what benefits to include in their Medigap policies, you should compare policies before buying. Compare the benefits and the premiums. Some policies may offer better benefits than others at a lower premium.

Keep in mind that Medicare pays only for services determined to be medically necessary and only the amount Medicare determines to be reasonable. Most Medigap policies do not pay for services Medicare finds unnecessary, and some may not pay for charges in excess of Medicare's approved amount.

## Basic Medigap Policy

The National Association of Insurance Commissioners (NAIC), which shares responsibility under law to develop federal minimum standards for Medigap policies, has established standards requiring that, as a minimum, a Medigap policy must include coverage for:

* Either all or none of the Medicare Part A inpatient hospital deductible amount ($628 per benefit period in 1991).

* The Part A coinsurance amount ($157 per day in 1991) for the 61st through the 90th day of hospitalization in each Medicare benefit period.

* The Part A coinsurance amount ($314 per day in 1991) for each of Medicare's 60 non-renewable lifetime hospital inpatient reserve days used.

* Ninety percent of Medicare Part A eligible expenses for a lifetime maximum of 365 days after all Medicare hospital benefits are exhausted.

* The reasonable cost of the first three pints of blood or equivalent quantities of packed red blood cells per calendar year unless replaced in accordance with federal regulations.

* The Part B coinsurance amount (generally 20% of eligible expenses) after the policyholder pays the $100 annual deductible.

While nearly all of the States have adopted minimum benefit standards, there may be differences in basic Medigap policies from State to State. So, to find out what standards are in effect in your State and whether they apply to your Medigap policy, check with your State insurance department.

A State may adopt minimum benefit standards that are more stringent than those in the NAIC model regulation, and they may or may not apply to your policy, depending on when it was issued. Moreover, these standards apply only to private policies meeting the definition of a "Medicare supplemental policy" under federal law. That definition specifically excludes policies or plans of employers and labor organizations, and limited benefit policies, some of which are discussed on page 6.

## Coordinated Care Plans

If you are enrolled in a coordinated care plan you probably do not need Medigap insurance. Coordinated care plans, also called managed care and prepayment plans, include health maintenance organizations (HMOs) and competitive medical plans (CMPs).

They might be thought of as a combination insurance company and doctor/hospital. Like an insurance company, they cover health care costs in return for a monthly premium, and like a doctor or hospital, they furnish health care. People who join are generally required to receive health services directly from physicians and other providers affiliated with the plan.

Medicare beneficiaries are eligible to enroll in a coordinated care plan if they reside in the plan's service area and are enrolled in Medicare Part B.

If you enroll in a coordinated care plan, Medicare pays the plan a fixed amount each month to provide you with all Medicare-approved services. HMOs and CMPs are permitted to charge enrollees a monthly premium in place of Medicare's deductibles and coinsurance amounts.

However, in some areas of the country, HMOs and CMPs do not charge a premium to Medicare members. Some plans also offer services beyond those covered by Medicare, such as certain preventive services.

## Group Insurance

There are two types of group insurance available. The first is purchased through an employer. The second is purchased through a voluntary association.

**Employer Group Insurance for Retirees.** Many working people are covered by an employer-sponsored group health plan. If you have such coverage, find out if it can be continued or converted to suitable individual coverage when you retire. Check the price and the benefits, including benefits for your spouse. Employer group health insurance that is continued or converted after retirement usually has the advantage of having no waiting periods or exclusions for a preexisting condition.

**Special Rules for Working People Age 65 or Older.** If you are 65 or over, and you or your spouse work, then Medicare is secondary payer for you to your employer group health plan (EGHP) coverage. This means that the employer plan pays first on your hospital and medical bills. If the employer plan does not pay all of your expenses, Medicare may pay secondary benefits.

This requirement applies to EGHPs which have at least one sponsoring or contributing employer with 20 or more employees. Employers who have 20 or more employees are required to offer the same health benefits, under the same conditions, to employees age 65 or over, and to employees' spouses who are 65 or over, that they offer to younger employees and spouses.

You may accept or reject coverage under the EGHP. If you do not accept the employer plan's coverage, Medicare will be the primary payer for Medicare-covered health services that you receive. If you choose Medicare as your primary payer, an employer may not offer to provide you with a plan that pays secondary benefits for Medicare-covered services, or to subsidize such coverage. An employer may, however, offer a plan that pays for health care services not covered by Medicare, such as hearing aids, routine dental care, and physical checkups.

**Special Rules for Disabled Medicare Beneficiaries under 65.** Medicare is also secondary for people under age 65 who are entitled to Medicare based on disability and who have large group health plan (LGHP) coverage as an employee, employer, self-employed person, business associate of an employer, or a family member of any of these people. An LGHP must not treat any of these people differently because they are disabled and have Medicare.

An LGHP is a plan of, or contributed to by, an employer or employee organization which covers the employees of at least one employer with 100 or more employees. Disabled persons also have the option of accepting or rejecting LGHP coverage. If they reject the plan, Medicare becomes their primary payer, and the employer may not offer to provide or to subsidize supplemental coverage, except for items and services not covered by Medicare.

**Special Rules for Medicare Beneficiaries with Permanent Kidney Failure.** Medicare is secondary payer to EGHPs for up to 18 months for beneficiaries who have Medicare solely because of permanent kidney failure. This requirement applies only to those with permanent kidney failure, whether they have their own coverage under an EGHP or are covered under an EGHP as dependents.

The period when the EGHP is primary begins with the earlier of:

* **The first month in which the person becomes entitled to Medicare Part A, or**

* **The first month in which an individual would have been entitled to Part A, if he had filed for Medicare benefits.**

Thus, EGHPs may be primary for a period of up to 21 months: the first three months of dialysis (a period during which an individual generally is not entitled to Medicare benefits) plus the first 18 months of Medicare entitlement. After the period of up to 21 months expires, Medicare is primary payer and the plan is secondary. The HCFA pamphlet, *Medicare Coverage of Kidney Dialysis and Kidney Transplant Services,* contains more information about Medicare and kidney disease. You can get a free copy from the Social Security Administration, HCFA, or the Consumer Information Center, Department 59, Pueblo, CO 81009 (refer to publication number 603V).

**Association Group Insurance.** Many organizations, other than employers, offer various kinds of group health insurance coverage to their members 65 and over. Just because you are buying through a group does not mean that you are getting a low rate. Group insurance can be as expensive or more costly than comparable coverage under individual policies. Be sure you understand the benefits included and then compare prices.

## THE FOLLOWING TYPES OF COVERAGE ARE GENERALLY LIMITED IN SCOPE AND ARE NOT SUBSTITUTES FOR MEDIGAP INSURANCE OR COORDINATED CARE PLANS.

### Long-Term Care Insurance

Insurance is available to cover custodial care in a nursing facility (NF) as well as certain care in the home. Policies also are available to pay for care in a skilled nursing facility (SNF) after your Medicare benefits run out (see page 12 for an explanation of the Medicare skilled nursing care benefit).

If you are in the market for long-term care insurance, be sure you know which types of nursing homes and services are covered by the different policies available. And if you buy a policy, make sure it does not duplicate skilled nursing facility (SNF) coverage provided by any coordinated care plan or other coverage you have. Remember that custodial care, which is the type of care most persons in nursing homes require, is not covered by Medicare or most Medigap policies.

For more detailed information about long-term care insurance, request a copy of *A Shopper's Guide to Long-Term Care Insurance* from either your State insurance department or the National Association of Insurance Commissioners, 120 W. 12th Street, Suite 1100, Kansas City, MO 64105.

### Hospital Confinement Indemnity Insurance

Hospital confinement indemnity coverage is insurance that pays a fixed amount for each day you are hospitalized up to a designated number of days. Some coverage may have added benefits such as surgical benefits or skilled nursing home confinement benefits.

### Specified Disease Insurance

Specified disease insurance, which is not available in some States, provides benefits for only a single disease, such as cancer, or a group of specified diseases. The value of such coverage depends on the chance you will get the specific disease or diseases covered. Benefits are usually limited to payment of a fixed amount for each type of treatment. Benefits are not designed to fill gaps in Medicare coverage.

## DO YOU NEED PRIVATE HEALTH INSURANCE IN ADDITION TO MEDICARE? NOT EVERYONE DOES.

Before buying insurance to supplement Medicare, ask yourself whether you need private health insurance in addition to Medicare. Not everyone does. If you are uncertain as to whether you need additional coverage, you may want to discuss the matter with someone you know and who under-

stands insurance and your financial situation. The best time to do this is before you reach age 65. Some State insurance departments offer health insurance counselling services. You may want to check to determine whether your State does.

### Medicaid Recipients

Low-income people who are eligible for Medicaid usually do not need additional insurance. Individuals who are eligible for regular Medicaid benefits qualify for certain health care benefits beyond those covered by Medicare, such as long-term nursing home care.

### Coordinated Care Plan Enrollees

If you are a Medicare beneficiary enrolled in a health maintenance organization (HMO) or competitive medical plan (CMP) which has a contract with Medicare, you probably do not need a Medigap policy (see page 4).

### Assistance For Low-Income Elderly

Medicare beneficiaries should be aware that limited financial assistance is available through Medicaid for paying a share of acute care costs for certain low-income elderly and disabled Medicare beneficiaries. If your annual income is below the national poverty level and you do not have access to many financial resources, you may qualify for government assistance in paying Medicare monthly premiums and at least some of the Medicare deductibles and coinsurance amounts. The national poverty income levels for 1991 will be announced in February 1991. In 1990 the limits were $6,280 for one person and $8,420 for a married couple. The maximum annual income for qualifying for assistance may vary by State. If you qualify, this financial assistance is available through your State's medical assistance (Medicaid) office. For further information contact your State or local social service agency and ask about the "Qualified Medicare Beneficiary" benefit.

## TIPS ON SHOPPING FOR HEALTH INSURANCE

**Shop Carefully Before You Buy.** Policies differ widely as to coverage and cost, and companies differ as to service. Contact different companies and compare the policies carefully before you buy.

**Don't Buy More Policies Than You Need.** Duplicate coverage is costly and unnecessary. A single comprehensive policy is better than several policies with overlapping or duplicate coverage.

**Consider Your Alternatives.** Depending on your health care needs and finances, you may want to consider continuing the group coverage you have at work; joining an HMO, CMP or other coordinated care plan; or buying a Medigap policy.

**Check For Preexisting Condition Exclusions.** In evaluating a policy, determine whether it limits its coverage for existing health conditions. Many policies do not cover health problems that you have at the time of purchase. Preexisting conditions are generally health problems you went to see a physician about within the six months before the date the policy went into effect. Don't be misled by the phrase "no medical examination required." If you have had a health problem, the insurer might not cover you for expenses connected with that problem. Most states require Medigap policies to cover preexisting conditions after the policy has been in effect for 6 months.

**Beware of Replacing Existing Coverage.** Be suspicious of a suggestion that you give up your policy and buy a replacement. If you do drop one policy and switch to another, make sure you have a good reason for doing so. On the other hand, don't keep inadequate policies simply because you have had them a long time. You don't get credit with a company just because you've paid for a policy many years.

If you decide to buy a replacement Medigap policy, the replacement policy cannot impose new preexisting condition exclusions, waiting periods and probationary periods for benefits similar to those under the old policy. You also must be given credit for the time spent under the old policy in determining when such restrictions expire under the new policy. Tougher standards also have been adopted to prevent the sale of duplicate or unnecessary insurance.

**Be Aware of Maximum Benefits.** Most policies have some type of limit on benefits. They may restrict either the dollar amount that will be paid for treatment of a condition or the number of days of care for which payment will be made.

**Check Your Right to Renew.** Beware of policies that let the company refuse to renew your policy on an individual basis. These policies provide the least permanent coverage. Most policies cannot be canceled by the company unless all policies of that type are canceled in the State. Therefore, these policies cannot be canceled because of claims or disputes. Some policies are guaranteed renewable for life. This means that although your insurance premiums may be adjusted from time to time, the insurance company cannot cancel your coverage.

Policies that can be renewed automatically offer added protection. Most States now require that newly issued Medigap policies be automatically renewable unless the premiums are not paid or the policyholder made significant misrepresentations about his or her health on the application.

**Be Aware That Policies to Supplement Medicare Are Neither Sold Nor Serviced by the State or Federal Governments.** State insurance departments approve policies sold by insurance companies but approval only means the company and policy meet requirements of State law. Do not believe statements that insurance to supplement Medicare is a government-sponsored program. If anyone tells you that he or she is from the government and later tries to sell you an insurance policy, report that person to your State insurance department or federal authorities. This type of misrepresentation is a violation of federal and State law. It is also unlawful for a company or agent to falsely claim that a policy has been approved for sale in any State in which it has not received State approval, or to use fraudulent means to gain approval.

**Know With Whom You're Dealing.** A company must meet certain qualifications to do business in your State. This is for your protection. Agents also must be licensed by your State and may be required by the State to carry proof of licensure showing their name and the company they represent. If the agent cannot verify that he or she is licensed, do not buy from that person. A business card is not a license.

**Keep Agents' and/or Companies' Names, Addresses and Telephone Numbers.** Write down the agents' and/or companies' names, addresses and telephone numbers or ask for a business card that provides all that information.

**Take Your Time.** Do not be pressured into buying a policy by an agent who tells you that there is a limited enrollment period. Principled salespeople will not rush you. If you are not certain whether a program is worthy, ask the salesperson to explain it to a friend.

**If You Decide To Buy, Complete the Application Carefully.** Some companies ask for detailed medical information. If they do and you leave out any of the medical information requested, coverage could be refused for a period of time for any medical condition you neglected to mention. The company also could deny a claim for treatment of an undisclosed condition and/or cancel your policy. Do not believe anyone who tells you that your medical history on an application is not important.

**Look For an Outline of Coverage.** You must be given a clearly worded summary of the policy. READ IT CAREFULLY.

**Do Not Pay Cash.** Pay by check, money order or bank draft made payable to the insurance company, not to the agent or anyone else.

**Policy Delivery or Refunds Should be Prompt.** The insurance company should deliver a policy within 30 days. If it does not, contact the company and obtain in writing the reason for the delay. If 60 days go by without information, contact your State insurance department.

**Use the "Free-Look" Provision.** Insurance companies are required to give you at least 30 days to review a Medigap policy. If you decide you don't want the policy, send it back to the agent or company within 30 days of receiving it and ask for a refund of all premiums you paid. Contact your State insurance department if you have a problem getting a refund.

## For Your Protection

Federal criminal and civil penalties can be imposed against any company or agent who knowingly sells you a policy that substantially duplicates coverage you already have, unless the policy also pays duplicate benefits. There are also penalties for claiming that a policy meets legal standards for federal certification when it does not, and for using the mail for the delivery of advertisements offering for sale a Medigap policy in a State in which it has not received State approval.

Additionally, it is illegal under federal law for an individual or company to misuse the names, letters, symbols or emblems of the U.S. Department of Health and Human Services, the Social Security Administration, and the Health Care Financing Administration. It also is illegal to use the names, letters, symbols or emblems of their various programs. This law is aimed primarily at mass marketers who use this information on mail solicitations to either imply or claim that the product they are selling—whether it be insurance or something else—has either been endorsed or is being sold by the U.S. Government.

If you believe you have been the victim of any unlawful sales practices, contact your State insurance department immediately (see pages 16 to 19). If you believe that federal law has been violated you may call the toll-free number listed in the front of this booklet. In most cases, however, your State insurance department can offer the most assistance in resolving insurance-related problems.

## WHAT MEDICARE PAYS AND DOESN'T PAY

**As explained earlier, Medicare does not pay the entire cost for all services covered by the program. You or your insurance company must pay certain deductibles and coinsurance amounts and any charges in excess of Medicare's approved amount for covered services and supplies.**

**The charts on pages 10 and 11 describe Medicare benefits only. The "You Pay" column itemizes expenses you are responsible for and must pay out of your own pocket or through the purchase of some type of private insurance as described in this booklet.**

## MEDICARE (PART A): HOSPITAL INSURANCE-COVERED SERVICES PER BENEFIT PERIOD

| Services | Benefit | Medicare Pays** | You Pay** |
|---|---|---|---|
| HOSPITALIZATION<br>Semiprivate room and board, general nursing and miscellaneous hospital services and supplies. | First 60 days | All but $628 | $628 |
| | 61st to 90th day | All but $157 a day | $157 a day |
| | 91st to 150th day* | All but $314 a day | $314 a day |
| | Beyond 150 days | Nothing | All costs |
| POSTHOSPITAL SKILLED NURSING FACILITY CARE<br>You must have been in a hospital for at least 3 days and enter a Medicare-approved facility generally within 30 days after hospital discharge. (2) | First 20 days | 100% of approved amount | Nothing |
| | Additional 80 days | All but $78.50 a day | $78.50 a day |
| | Beyond 100 days | Nothing | All costs |
| HOME HEALTH CARE | Medically necessary skilled care, home health aide services, medical supplies, etc. | Full cost of services; 80% of approved amount for durable medical equipment. | Nothing for services; 20% of approved amount for durable medical equipment. |
| HOSPICE CARE<br>Available to terminally ill. | As long as doctor certifies need. | All but limited costs for outpatient drugs and inpatient respite care. | Limited cost sharing for outpatient drugs and inpatient respite care. |
| BLOOD | Blood | All but first 3 pints per calendar year. | For first 3 pints.*** |

* 60 reserve days may be used only once; days used are not renewable.

** These figures are for 1991 and are subject to change each year.

*** To the extent the blood deductible is met under one part of Medicare during the calendar year, it does not have to be met under the other part.

(1) A benefit period begins on the first day you receive service as an inpatient in a hospital and ends after you have been out of the hospital and have not received skilled care in any other facility for 60 days in a row.

(2) Medicare and most private insurance will not pay for custodial care in a nursing home.

## MEDICARE (PART B): MEDICAL INSURANCE-COVERED SERVICES PER CALENDAR YEAR

| Services | Benefit | Medicare Pays | You Pay |
|---|---|---|---|
| MEDICAL EXPENSE<br><br>Physician's services, inpatient and outpatient medical and surgical services and supplies, physical and speech therapy, diagnostic tests, durable medical equipment, etc. | Medicare pays for medical services in or out of the hospital. | 80% of approved amount (after $100 deductible). | $100 deductible* plus 20% of approved amount (plus any charge above approved amount).** |
| CLINICAL LABORATORY SERVICES | Blood tests, biopsies, urinalysis, etc. | Full cost of services. | Nothing for services. |
| HOME HEALTH CARE | Medically necessary skilled care, home health aide services, medical supplies, etc. | Full cost of services; 80% of approved amount for durable medical equipment. | Nothing for services; 20% of approved amount for durable medical equipment. |
| OUTPATIENT HOSPITAL TREATMENT | Unlimited if medically necessary. | 80% of approved amount (after $100 deductible). | Subject to deductible plus 20% of approved amount. |
| BLOOD | Blood | 80% of approved amount (after $100 deductible and starting with 4th pint). | For first 3 pints plus 20% of approved amount for additional pints (after $100 deductible).*** |

* Once you have had $100 of expense for covered services in 1991, the Part B deductible does not apply to any further covered services you receive for the rest of the year.

** You pay for charges higher than the amount approved by Medicare unless the doctor or supplier agrees to accept Medicare's approved amount as full payment for services rendered (see footnote on page 2).

*** To the extent the blood deductible is met under one part of Medicare during the calendar year, it does not have to be met under the other part.

## MEDICARE HOSPITAL INSURANCE BENEFITS (PART A)

When all program requirements are met, Medicare Part A will help pay for medically necessary inpatient care in a hospital, for medically necessary inpatient care in a skilled nursing facility, and for hospice care. In addition, Part A pays the full cost of medically necessary home health care and 80 percent of the approved cost for durable medical equipment supplied under the home health benefit.

Part A covers all services customarily furnished by hospitals and skilled nursing facilities. Part A does not cover private duty nursing, charges for a private room, unless medically necessary, or convenience items such as a telephone or television in your room. Nor does Part A cover the first 3 pints of blood you receive during a calendar year. You cannot, however, be charged for blood if it is replaced by a blood plan or through a blood donation in your behalf, or if you have met the Part B blood deductible for the calendar year. To the extent the blood deductible is met under one part of Medicare, it does not have to be met under the other during the calendar year.

### Benefit Periods

Medicare Part A benefits are paid on the basis of benefit periods. A benefit period begins the first day you receive Medicare covered service in a hospital and ends when you have been out of a hospital or skilled nursing facility for 60 days in a row. It also ends if you remain in a skilled nursing facility but do not receive any skilled care there for 60 days in a row. If you enter a hospital again after 60 days, a new benefit period begins. All Part A benefits (except for any lifetime reserve days used) are renewed. There is no limit to the number of benefit periods you can have for hospital or skilled nursing facility care. However, special limited benefit periods apply to hospice care (see page 13.)

### Inpatient Hospital Care

Part A pays for all covered services for the first 60 days of inpatient hospital care in a benefit period except for $628, which is the hospital deductible for 1991. For the next 30 days, Part A pays for all covered services except for a coinsurance amount you or your insurance company must pay. The coinsurance amount in 1991 is $157 a day. Every person enrolled in Part A also has a lifetime reserve of 60 days for inpatient hospital care. These days may be used whenever more than 90 days of inpatient hospital care are needed in a benefit period. When a reserve day is used, Part A pays all covered expenses except for a coinsurance amount of $314 a day in 1991.

### Skilled Nursing Facility Care

Medicare Part A can help pay for up to 100 days of extended care services in a skilled nursing facility (SNF) during a benefit period. All approved amounts for the first 20 days of care are fully paid by Medicare. All approved amounts for the next 80 days are paid by Medicare except for a daily coinsurance amount. The daily coinsurance amount in 1991 is $78.50.

To qualify for Medicare coverage for SNF care you must have been in a hospital at least three consecutive days (not counting the day of discharge) before entering a SNF. The admission generally must be within 30 days of your discharge from the hospital. Your physician must certify that you need, and you receive, skilled nursing or skilled rehabilitation services on a daily basis. The care also must be for the condition for which you were treated in the hospital.

A SNF is a special kind of facility that primarily furnishes skilled nursing and rehabilitation services. It may be a separate facility or a distinct part of another facility, such as a hospital or a nursing facility (NF). Medicare benefits are payable only if you require a skilled level of care and the care is provided in a SNF certified

by Medicare. Most nursing homes in the United States are not SNFs. Medicare will not pay for your stay in a SNF if the services you receive are mainly personal care or custodial services, such as help in walking, getting in and out of bed, eating, dressing, bathing and taking medicine.

### Home Health Care

Part A pays the cost of medically necessary home health visits for homebound beneficiaries. Coverage includes the intermittent services of a skilled nurse. The services of physical and speech therapists also are covered when they are furnished through a Medicare-certified home health agency. If you require any of these services and are confined to your home and are under the care of a physician, Part A can also help pay for other services. These include necessary part-time or intermittent home health aide and skilled nursing services, occupational therapy, medical social services, and medical supplies. Coverage is also provided for a portion of the cost of durable medical equipment provided under a plan of care set up and overseen by a physician. Part A does not cover full-time nursing care, drugs, meals delivered to your home, or homemaker services that are primarily to assist you in meeting personal care or housekeeping needs.

### Hospice Care

Medicare beneficiaries certified as terminally ill may elect to receive hospice care rather than regular Medicare benefits for their terminal illness. Part A can pay for two 90-day hospice benefit periods, a subsequent period of 30 days, and a subsequent extension of unlimited duration.

Beneficiaries enrolled in a Medicare-certified hospice program receive medical and support services necessary for symptom management and pain relief. When these services—most of which are provided in the beneficiary's home—are furnished by a Medicare-certified facility, the coverage includes: physician services, nursing care, medical appliances and supplies (including outpatient drugs for symptom management and pain relief), short-term inpatient care, counseling, therapies, and home health aide and homemaker services. There is no deductible. Patients must pay only limited cost-sharing for outpatient drugs and inpatient respite care. In the event the patient requires medical services for a condition unrelated to the terminal illness, regular Medicare benefits are available.

## MEDICARE MEDICAL INSURANCE BENEFITS (PART B)

Part B helps pay for **physician services** no matter where you receive them—at home, in the doctor's office, in a clinic or hospital—and other related medical services and supplies. **Outpatient hospital services**, X-rays and laboratory tests are covered as are certain **ambulance services**, and the purchase or rental of **durable medical equipment**, such as wheelchairs.

Part B also covers **physical therapy** and **speech pathology** services in a doctor's office, as an outpatient, or in your home. Outpatient prescription drugs furnished hospice enrolles are covered as are non-self administrable drugs that are provided as part of a physician's services, and special drugs provided during the first year after an organ transplantation. And if you qualify for home health care but do not have Medicare Part A, then Part B pays for all covered home health visits. You have no deductible or coinsurance for home health services. You do, however, have to pay 20 percent of the cost of any durable medical equipment supplied under the home health benefit.

As of January 1, 1991, routine **mammograms** for the early detection of breast cancers were added as a Part B benefit. Medicare will pay a maximum of 80 percent of $55, or not more than $44 for the screenings. Women 65 or older can use the benefit once every two years, while certain

younger disabled women covered by Medicare can use it once a year.

When you use your Part B benefits, you will be required to pay the first $100 (the annual deductible) of charges approved by Medicare. After that, Medicare Part B generally pays 80 percent of the approved amount for covered services you receive the rest of the year. You or your insurance company must pay the other 20 percent. If a doctor or supplier charges more than Medicare's approved amount, you must pay the difference (See footnote on page 2).

## EXPENSES NOT COVERED BY MEDICARE

Medicare does not cover certain kinds of care, charges or supplies. Among them are:

* Private duty nursing.
* Skilled nursing home care costs beyond 100 days per benefit period.
* Custodial nursing home care.
* Physician charges above Medicare's approved amount.
* Most outpatient prescription drugs.
* Care received outside the USA, except under limited circumstances in Canada and Mexico.
* Dental care or dentures.
* Checkups and most routine immunizations.
* Cosmetic surgery.
* Routine foot care.
* Examinations for and the cost of eyeglasses or hearing aids.

## ENROLLING IN PART B

You are automatically enrolled in Part B when you enroll in Part A unless you state that you don't want it. Although you do not have to purchase Part B it is an excellent buy because the Federal Government pays most of the actual cost. If you do not now have Part B coverage and you want it, you may enroll during the general enrollment period from January 1 through March 31 each year. It is available to you regardless of whether you qualify for premium-free Part A coverage. If you are covered under your or your spouse's employer group health plan, you may enroll in Part B when the employment on which that coverage is based comes to an end, or when the plan is terminated, whichever occurs first.

## PAYING FOR MEDICARE

Part A is financed through part of the Social Security (FICA) tax paid by all workers and their employers. You do not have to pay a monthly premium for Medicare Part A if you or your spouse are entitled to benefits under either the Social Security or Railroad Retirement systems, or worked a sufficient period of time in federal, State, or local government employment to be insured.

Some disabled persons who do not meet the age requirement of 65 may also qualify for benefits. If you do not meet the qualifications for premium-free Part A benefits and you are at least 65 years old, you may purchase the coverage. The monthly premium is $177 in 1991.

### Part B Monthly Premium

Part B is optional and is offered to all beneficiaries when they enroll in Part A. It also may be purchased by individuals who do not qualify for premium-free Part A coverage. The monthly Part B premium is $29.90 in 1991.

## For additional help

If you have any questions about Medicare, contact your nearest Social Security office or the Medicare insurance carrier in your area.
The carriers are listed in the back of *The Medicare Handbook*, which is available from the Social Security office.

For information on private insurance to supplement Medicare, check your State insurance department or State agency on aging (see the lists in the back of this booklet).

If you bought or are considering buying a health insurance policy, the company or its agent should answer your questions. If you do not get the service you feel you deserve, discuss the matter with your State insurance department.

## STATE INSURANCE DEPARTMENTS

Each State has its own laws and regulations governing all types of insurance. The offices listed in this section are responsible for enforcing these laws, as well as providing the public with information about insurance.

**Alabama**
Alabama Insurance Department
135 South Union Street
Montgomery, AL 36130-3401
(205) 269-3550

**Alaska**
Alaska Insurance Department
3601 C Street, Suite 740
Anchorage, AK 99503
(907) 562-3626

**American Samoa**
American Samoa Insurance Department
Office of the Governor
Pago Pago, AS 96797
011-684/633-4116

**Arizona**
Arizona Insurance Department
Consumer Affairs and Investigation Division
3030 N. Third Street
Phoenix, AZ 85012
(602) 255-4783

**Arkansas**
Arkansas Insurance Department
Consumer Service Division
400 University Tower Bldg.
12th and University Streets
Little Rock, AR 72204
(501) 371-1813

**California**
California Insurance Department
Consumer Services Division
3450 Wilshire Boulevard
Los Angeles, CA 90010
1-800-233-9045

**Colorado**
Colorado Insurance Division
303 W.Colfax Avenue, 5th Floor
Denver, CO 80204
(303) 620-4300

**Connecticut**
Connecticut Insurance Department
165 Capitol Avenue
State Office Building
Hartford, CT 06106
(203) 297-3800

**Delaware**
Delaware Insurance Department
841 Silver Lake Boulevard
Dover, DE 19901
(302) 739-4251

**District of Columbia**
District of Columbia Insurance
613 G Street, NW
Room 619
P.O. Box 37200
Washington, DC 20001-7200
(202) 727-8017

**Florida**
Florida Department of Insurance
State Capitol
Plaza Level Eleven
Tallahassee, FL 32399-0300
Toll Free (Within State)
1-800-342-2762
(904) 488-0030

**Georgia**
Georgia Insurance Department
2 Martin L. King, Jr., Dr.
Room 716 West Tower
Atlanta, GA 30334
(404) 656-2056

**Guam**
Guam Insurance Department
855 W. Marine Drive
P.O. Box 2796
Agana, Guam 96910
011-671/477-1040

**Hawaii**
Hawaii Department of Commerce
and Consumer Affairs Insurance Division
P.O. Box 3614
Honolulu, HI 96811
(808) 548-5450

**Idaho**
Idaho Insurance Department
Public Service Department
500 South 10th Street
Boise, ID 83720
(208) 334-3102

**Illinois**
Illinois Insurance Department
320 West Washington Street
4th Floor
Springfield, Il 62767
(217) 782-4515

**Indiana**
Indiana Insurance Department
311 West Washington Street
Suite 300
Indianapolis, IN 46204
Toll Free (Within State)
1-800-622-4461
(317) 232-2395

**Iowa**
Iowa Insurance Division
Lucas State Office Bldg.
E. 12th & Grand Sts.
6th Floor
Des Moines, IA 50319
(515) 281-5705

**Kansas**
Kansas Insurance Department
420 S.W. 9th Street
Topeka, KS 66612
(913) 296-3071

**Kentucky**
Kentucky Insurance Department
229 West Main Street
P.O. Box 517
Frankfort, KY 40602
(502) 564-3630

**Louisiana**
Louisiana Insurance Department
P.O. Box 94214
Baton Rouge, LA 70804-9214
(504) 342-5900

**Maine**
Maine Bureau of Insurance
Consumer Division
State House, Station 34
Augusta, ME 04333
(207) 582-8707

**Maryland**
Maryland Insurance Department
Complaints and Investigation Unit
501 St. Paul Place
Baltimore, MD 21202-2272
(301) 333-6300

**Massachusetts**
Massachusetts Insurance Division
Consumer Services Section
280 Friend Street
Boston, MA 02114
(617) 727-7189

**Michigan**
Michigan Insurance Department
P.O. Box 30220
Lansing, MI 48909
(517) 373-0220

**Minnesota**
Minnesota Insurance Department
Department of Commerce
133 E. 7th Street
St. Paul, MN 55101
(612) 296-4026

**Mississippi**
Mississippi Insurance Department
Consumer Assistance Division
P.O. Box 79
Jackson, MS 39205
(601) 359-3569

**Missouri**
Missouri Division of Insurance
Consumer Services Section
P.O. Box 690
Jefferson City, MO 65102-0690
(314) 751-2640
Toll Free (Within State)
1-800-726-7390

**Montana**
Montana Insurance Department
126 N. Sanders
Mitchell Building
P.O. Box 4009, Room 270
Helena, MT 59604
Toll Free (Within State)
1-800-332-6148
(406) 444-2040

**Nebraska**
Nebraska Insurance Department
Terminal Building
941 O Street, Suite 400
Lincoln, NE 68508
(402) 471-2201

**Nevada**
Nevada Department of Commerce
Insurance Division
Consumer Section
1665 Hot Springs Road
Capitol Complex
Carson City, NV 89701
(702) 687-4270

**New Hampshire**
New Hampshire Insurance Department
Life and Health Division
169 Manchester Street
Concord, NH 03301
(603) 271-2261

**New Jersey**
New Jersey Insurance Department
20 West State Street
Roebling Building
Trenton, NJ 08625
(609) 292-4757

**New Mexico**
New Mexico Insurance Department
P.O. Box 1269
Santa Fe, NM 87504-1269
(505) 827-4500

**New York**
New York Insurance Department
160 West Broadway
New York, NY 10013
New York City
(212) 602-0203
Toll Free (Within State outside of NYC)
1-800-342-3736

**North Carolina**
North Carolina Insurance Department
Consumer Services
Dobbs Building
P.O. Box 26387
Raleigh, NC 27611
(919) 733-2004

**North Dakota**
North Dakota Insurance Department
Capitol Building
5th Floor
Bismarck, ND 58505
(701) 224-2440
Toll Free (Within State)
1-800-247-0560

**Ohio**
Ohio Insurance Department
Consumer Services Division
2100 Stella Court
Columbus, OH 43266-0566
(614) 644-2673

**Oklahoma**
Oklahoma Insurance Department
P.O. Box 53408
Oklahoma City, OK 73152-3408
(405) 521-2828

**Oregon**
Oregon Department of Insurance and Finance
Insurance Division/Consumer Advocate
21 Labor and Industry Building
Salem, OR 97310
(503) 378-4484

**Pennsylvania**
Pennsylvania Insurance Department
Consumer Services Bureau
1321 Strawberry Square
Harrisburg, PA 17120
(717) 787-2317

**Puerto Rico**
Puerto Rico Insurance Department
Fernandez Juncos Station
P.O. Box 8330
Santurce, PR 00910
(809) 722-8686

### Rhode Island
Rhode Island Insurance Division
233 Richmond Street
Suite 233
Providence, RI 02903-4233
(401) 277-2223

### South Carolina
South Carolina Insurance Department
Consumer Assistance Section
P.O. Box 100105
Columbia, SC 29202-3105
(803) 737-6140

### South Dakota
South Dakota Insurance Department
Enforcement
910 E. Sioux Avenue
Pierre, SD 57501-3940
(605) 773-3563

### Tennessee
Tennessee Department of Commerce
and Insurance
Policyholders Service Section
4th Floor
500 James Robertson Parkway
Nashville, TN 3737243-0582
Toll Free (Within State)
1-800-342-4029
(615) 741-4955

### Texas
Texas Board of Insurance
Complaints Division
1110 San Jacinto Blvd.
Austin, TX 78701-1998
(512) 463-6501

### Utah
Utah Insurance Department
Consumer Services
3110 State Office Building
Salt Lake City, UT 84114
(801) 538-3800

### Vermont
Vermont Department of Banking and Insurance
Consumer Complaint Division
120 State Street
Montpelier, VT 05602
(802) 828-3301

### Virgin Island
Virgin Islands Insurance Department
Kongens Garde No. 18
St. Thomas, VI 00802
(809) 774-2991

### Virginia
Virginia Insurance Department
Consumer Services Division
700 Jefferson Building
P.O. Box 1157
Richmond, VA 23209
(804) 786-7691

### Washington
Washington Insurance Department
Insurance Building AQ21
Olympia, WA 98504-0321
Toll Free (Within State)
1-800-562-6900
(206) 753-7300

### West Virginia
West Virginia Insurance Department
2019 Washington Street, E
Charleston, WV 25305
(304) 348-3386

### Wisconsin
Wisconsin Insurance Department
Complaints Department
P.O. Box 7873
Madison, WI 53707
608/266-0103

### Wyoming
Wyoming Insurance Department
Herschler Building
122 W. 25th Street
Cheyenne, WY 82002
(307) 777-7401

The offices listed in this section are responsible for coordinating services for older Americans.

**Alabama**
Commission on Aging
136 Catoma Street
Montgomery, AL 36130
Toll Free (Within STate)
1-800-243-5463
(205) 242-5743

**Alaska**
Older Alaskans Commission
P.O. Box C, MS 0209
Juneau, AK 99811
(907) 465-3250

**American Samoa**
Territorial Administration on Aging
Government of American Samoa
Pago Pago, AS 96799
(684) 633-1251

**Arizona**
Department of Economic Security
Aging and Adult Administration
1400 W. Washington Street
Phoenix, AZ 85007
(602) 542-4446

**Arkansas**
Division of Aging and Adult Services
Donaghey Plaza South
Suite 1417
7th and Main Streets
P.O. Box 1417/Slot 1412
Little Rock, AR 72203-1437
(501) 682-2441

**California**
Department of Aging
1600 K Street
Sacramento,CA 95814
(916) 322-3887

**Colorado**
Aging and Adult Services
Department of Social Services
1575 Sherman St., 10th Floor
Denver, CO 80203-1714
(303) 866-3851

**Commonwealth of the Northern Mariana Islands**
Department of Community and Cultural Affairs
Civic Center
Commonwealth of the Northern Mariana Islands
Saipan, CM 96950
(607) 234-6011

**Connecticut**
Department on Aging
175 Main Street
Hartford, CT 06106
Toll Free (Within State)
1-800-443-9946
(203) 566-7772

**Delaware**
Division of Aging
Department of Health and Social Services
1901 N. DuPont Highway
New Castle, DE 19720
(302) 421-6791

**District of Columbia**
Office on Aging
1424 K Street, NW., 2nd Floor
Washington, DC 20005
(202) 724-5626
(202) 724-5622

**Federated States of Micronesia**
State Agency on Aging
Office of Health Services
Federated States of Micronesia
Ponape, E.C.I. 96941

**Florida**
Office of Aging and Adult Services
1317 Winewood Boulevard
Tallahassee, FL 32301
(904) 488-8922

**Georgia**
Office of Aging
Department of Human Resources
878 Peachtree Street, NE., Room 632
Atlanta, GA 30309
(404) 894-5333

**Guam**
Division of Senior Citizens
Department of Public Health and Social Services
P.O. Box 2816
Agana, GU 96910
(671) 734-2942

**Hawaii**
Executive Office on Aging
335 Merchant Street
Room 241
Honolulu, HI 96813
(808) 548-2593

**Idaho**
Office on Aging
Statehouse, Room 114
Boise, ID 83720
(208) 334-3833

**Illinois**
Department on Aging
421 E. Captiol Avenue
Springfield, IL 62701
(217) 785-2870

**Indiana**
Department of Human Services
251 North Illinois
P.O. Box 7083
Indianapolis, IN 46207-7083
(317) 232-7020

**Iowa**
Department of Elder Affairs
Suite 236, Jewett Building
914 Grand Avenue
Des Moines, IA 50319
(515) 281-5187

**Kansas**
Department on Aging
122-S Docking State Office Building
915 SW Harrison
Topeka, KS 66612-1500
(913) 296-4986

**Kentucky**
Division for Aging Services
Department for Social Services
275 E. Main Street
Frankfort, KY 40621
(502) 564-6930

**Louisiana**
Governor's Office of Elderly Affairs
P.O. Box 80374
Baton Rouge, LA 70898-0374
(504) 925-1700

**Maine**
Maine Committee of Aging
State House, Station 127
Augusta, ME 04333
(207) 289-3658

**Maryland**
State Agency on Aging
301 W. Preston Street
Baltimore, MD 21201
(301) 225-1102

**Massachusetts**
Executive Office of Elder Affairs
38 Chauncy Street
Boston, MA 02111
Toll Free (Within State)
1-800-882-2003
(617) 727-7750

**Michigan**
Office of Services to the Aging
P.O. Box 30026
Lansing, MI 48909
(517) 373-8230

**Minnesota**
Minnesota Board on Aging
Human Services Building
4th Floor
444 Lafayette Road
St. Paul MN 55155-3843
(612) 296-2770

**Mississippi**
Council on Aging
301 W. Pearl Street
Jackson, MS 39203-3092
Toll Free (Within State)
1-800-222-7622
(601) 949-2070

**Missouri**
Division of Insurance
Truman Building 630
P.O. Box 690
Jefferson, MO 65102-0690
Toll Free (Within State)
1-800-235-5503

**Montana**
Department of Family Services
P.O. Box 8005
Helena, MT 59604
(406) 444-5900

**Nebraska**
Department on Aging
Legal Services Developer
State Office Building
301 Centennial Mall South
Lincoln, NE 68509
(402) 471-2306

**Nevada**
Department of Human Resources
Division for Aging Services
505 E. King Street
Room 101
Carson City, NV 89710
(702) 885-4210

**New Hampshire**
Department of Health and Human Services
Division of Elderly and Adult Services
6 Hazen Drive
Concord, NH 03301
(603) 271-4394

**New Jersey**
Department of Community Affairs
Division on Aging
S. Broad and Front Sts.
CN 807
Trenton, NJ 08625-0807
(609) 292-0920

**New Mexico**
Agency on Aging
La Villa Rivera Bldg.
4th Floor
224 E. Palace Avenue
Santa Fe, NM 87501
Toll Free (Within State)
1-800-432-2080
(505) 827-7640

**New York**
State Office for the Aging
Agency Building
2 Empire State Plaza
Albany, NY 12223-0001
Toll Free (Within State)
1-800-342-9871
(518) 474-5731

**North Carolina**
Department of Human Resources
Division of Aging
1985 Umstead Drive
Raleigh, NC 27603
(919) 733-3983

**North Dakota**
Department of Human Services
Aging Services Division
State Capitol Building
Bismarck, ND 58505
(701) 224-2577

**Ohio**
Department of Aging
50 W. Broad Street
8th Floor
Columbus, OH 43266-0501
(614) 466-1221

**Oklahoma**
Department of Human Services
Aging Services Division
P.O. Box 25352
Oklahoma City, OK 73125
(405) 521-2327

**Oregon**
Department of Human Resources
Senior Services Division
313 Public Service Building
Salem, OR 97310
Toll Free (Within State)
1-800-232-3020
(503) 378-3751

**Palau**
State Agency on Aging
Department of Social Services
Republic of Palau
Koror, Palau 96940

**Pennsylvania**
Department of Aging
231 State Street
Barto Building
Harrisburg, PA 17101
(717) 783-1550

**Puerto Rico**
Governors Office of Elderly Affairs
Gericulture Commission
Box 11398
Santurce, PR 00910
(809) 722-2429 or 722-0225

**Republic of the Marshall Islands**
State Agency on Aging
Department of Social Services
Republic of the Marshall Islands
Marjuro, Marshall Islands 96960

**Rhode Island**
Department of Elderly Affairs
160 Pine Street
Providence, RI 02903
(401) 277-2858

**South Carolina**
Commission on Aging
400 Arbor Lake Drive
Suite B-500
Columbia, SC 29223
(803) 735-0210

**South Dakota**
Agency on Aging
Adult Services and Aging
Richard F. Kneip Building
700 Governors Drive
Pierre, SD 57501-2291
(605) 773-3656

**Tennessee**
Commission on Aging
706 Church Street
Suite 201
Nashville, TN 37219-5573
(615) 741-2056

**Texas**
Department on Aging
P.O. Box 12786
Capitol Station
Austin, TX 78711
(512) 444-2727

**Utah**
Division of Aging and Adult Services
120 North 200 West
P.O. Box 45500
Salt Lake City, UT 84145-0500
(801) 538-3910

**Vermont**
Office on Aging
Waterbury Complex
103 S. Main Street
Waterbury, VT 05676
(802) 241-2400

**Virgin Islands**
Department of Human Services
Barbel Plaza South
Charlotte Amalie
St. Thomas, VI 00802
(809) 774-0930

**Virginia**
Department for the Aging
700 Centre, 10th Floor
700 E. Franklin Street
Richmond, VA 23219-2327
Toll Free (Within State)
1-800-552-4464
(804) 225-2271

**Washington**
Aging & Adult Services Administration
Department of Social and Health Services
Mail Stop OB-44-A
Olympia, WA 98504
(206) 586-3768

**West Virginia**
Commission on Aging
State Capitol Complex
Holly Grove
Charleston, WV 25305
Toll Free (Within State)
1-800-642-3671
(304) 348-3317

**Wisconsin**
Bureau on Aging
Department of Health and Social Services
P.O. Box 7851
Madison, WI 53707
Toll Free (Within State)
1-800-242-1060
(608) 266-2536

**Wyoming**
Commission on Aging
Hathaway Building
First Floor
Cheyenne, WY 82002
Toll Free (Within State)
1-800-442-2766
(307) 777-7986

# POLICY CHECK-LIST

After reading this guide, you may find this check-list useful in assessing the benefits provided by a Medigap policy or in comparing policies.

| | POLICY 1 | | POLICY 2 | | POLICY 3 | |
|---|---|---|---|---|---|---|
| **Does the policy cover:** | **YES** | **NO** | **YES** | **NO** | **YES** | **NO** |
| Medicare Part A hospital deductible? | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ |
| * Medicare Part A hospital daily coinsurance? | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ |
| * Hospital care beyond Medicare's 150-day limit? | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ |
| Skilled nursing facility (SNF) daily coinsurance? | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ |
| SNF care beyond Medicare's limits? | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ |
| Medicare Part B annual deductible? | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ |
| * Medicare Part B coinsurance? | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ |
| Physician and supplier charges in excess of Medicare's approved amounts? | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ |
| * Medicare blood deductibles? | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ |
| **Other Policy Considerations** | | | | | | |
| Can the company cancel or non-renew the policy? | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ |
| What are the policy limits for covered services? | — | — | — | — | — | — |
| How much is the annual premium? | — | — | — | — | — | — |
| How often can the company raise the premium? | — | — | — | — | — | — |
| How long before existing health problems are covered? | — | — | — | — | — | — |
| Does the policy have a waiting period before any benefits will be paid? How long? | — | — | — | — | — | — |

* Most states now require that these benefits be included in all newly issued Medigap policies



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